AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (LACDMH)

I authorize the use and disclosure of my protected health information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name	**Last Name**
Street Address	**City, State, Zip**
IS Number	**Birth Date** / **Phone Number** ( )

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Countywide Housing Employment and Education Resource Development Division to use and/or to disclose my PHI, as described below, to Los Angeles Homeless Service Authority (LAHSA)/Homeless Management Information System (HMIS).

REDISCLOSURE NOTICE:
I understand that my PHI which is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Disclosed:
The following information will be disclosed in accordance with Projects for Assistance in Transitioning from Homelessness (P.A.T.H) grant reporting requirements such as: demographics, services, veteran status, co-occurring disorders, homeless history, outcomes (whether client was assisted with household goods, security deposits, maintenance, rehabilitation/repairs, eviction prevention and utility deposits.)

Purpose of Disclosure:
My PHI will be used to coordinate services and comply with P.A.T.H. grant reporting and outcome data requirements.
Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

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NOTICE

COPY OF THIS AUTHORIZATION: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment.

LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.

EXPIRATION DATE

Expiration Date: Date may not exceed five (5) years from the date signed. If no expiration date is indicated, expiration date will expire five (5) years from the date signed. This authorization is valid until: _____

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so: _____

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to LAC-DMH Countywide Housing, Employment, and Education Resource Development, 695 S. Vermont Ave., 10th Floor, Los Angeles, CA 90005. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

_____ _____

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so: _____